

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01646

1639 CERTIFICATE OF DEATH

Reg. Dist. No.

56

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL, WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL, WESTMINSTER, MD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FINKSBURG MD. RD</b>		d. STREET ADDRESS <b>FINKSBURG</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LILLIAN GERTRUDE ARMACOST</b>		4. DATE OF DEATH Month Day Year <b>FEB. 9 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 JAN 1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm A. Constantine</b>		14. MOTHER'S MAIDEN NAME <b>Zenobia Parrish</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus.</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from <b>10/31</b> , 19 <b>53</b> , to <b>2/9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2/9</b> , 19 <b>57</b> , and that death occurred at <b>11:20 PM</b> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>G. Allen Moulton</b>		ADDRESS (Street, city or town, state) <b>148 N. MAIN ST - Westminster, Md.</b>
PHYSICIAN'S NAME (Type) <b>G. ALLEN MOULTON, M.D.</b> <b>WESTMINSTER, MD.</b>		DATE SIGNED <b>2/10/57</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/12/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FINKSBURG CEMETERY</b>
22d. LOCATION (City, town, or county) <b>FINKSBURG, MD.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Murre, Jr.</b>		24a. REC'D BY REGISTRAR DATE <b>2-11-57</b>
24b. REGISTRAR'S SIGNATURE <b>H. G. Murre</b>		

# CERTIFICATE OF DEATH

BUREAU V. 81

1957 13 18

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01647

1640

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Sykesville + 1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>Martin</i> Last <i>Arrington</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>15</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 21, 1871</i>
9. AGE (In years last birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Austin Arrington</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Hirsch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-14-0006</i>	
17. INFORMANT Address <i>Mrs. Daisy Arrington - Sykesville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Sclerosis</i> 345x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1922</i> to <i>2/15/1957</i> , that I last saw the deceased alive on <i>2/14/1957</i> , and that death occurred at <i>9:50 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. E. Martin</i> M.D.		ADDRESS (Street, city or town, state) <i>Randallstown</i> DATE SIGNED <i>2/16/57</i>	
PHYSICIAN'S NAME (Type) <i>Wm. E. Martin</i>		<i>RANDALLSTOWN, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-17-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Liberty Freedom</i>	22d. LOCATION (City, town, or county) (State) <i>Elkensburg, Carroll, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Wright - Sykesville, Md.</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>2-16-57</i>	24b. REGISTRAR'S SIGNATURE <i>C. Harry Weir</i>

# CERTIFICATE OF DEATH

BUREAU V. S.

FEB 19 1957

RECEIVED

1641

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>		c. LENGTH OF STAY IN IB <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R.D.1 (Myers Dist.)</b>		e. STREET ADDRESS <b>Westminster, Md. R.D.1 (Myers Dist.)</b>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Larue</b> Last <b>Bankert</b>		4. DATE OF DEATH Month <b>2/12/57</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/30/1899 (1899)</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min. <b>57</b>	11. IF UNDER 24 HRS. Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife &amp; Shoe Factory Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home &amp; Shoe</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Otto Harmon</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ellen Sholl</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>197-05-9381</b>	
17. INFORMANT <b>Leonard P. Bankert</b>		Address <b>Westminster, Md. R.D.1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix</b> 171X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>18 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-25, 1955</b> , to <b>2-12, 1957</b> , that I last saw the deceased alive on <b>2-12, 1957</b> , and that death occurred at <b>8:30 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. R. Potter</b>		ADDRESS (Street, city or town, state) <b>12 W. King Littlestown, Pa.</b>	
PHYSICIAN'S NAME (Type) <b>L. L. POTTER</b>		DATE SIGNED <b>2-13-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/15/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		24a. REC'D BY REGISTRAR <b>DATE 2-4-57</b>	
ADDRESS <b>Littlestown, Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>Harriet Muller</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

1642  
CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Sykesville P.O.</u>	
3. NAME OF DECEASED (Type or print) First <u>Re Roy</u> Middle <u>Alphonse</u> Last <u>Beasman</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1902</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Painting</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. Beasman</u>		14. MOTHER'S MAIDEN NAME <u>Annie R. Starfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-16-0396</u>	
17. INFORMANT <u>Mrs. Claudia Beasman</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General carcinomatosis; primary site unknown.</u> 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>mixed <del>upper</del> neoplasm cervical lymph nodes</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>8-10 weeks</u> <u>6 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August</u> , 1956, to <u>6 February</u> , 1957, that I last saw the deceased alive on <u>6 February</u> , 1957, and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Liberty Road at Eldersburg, Sykesville, Md.</u>		PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr. M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Freedom</u>	22d. LOCATION (City, town, or county) (State) <u>Eldersburg, Carroll, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur N. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. S.

FEB 11 1957

RECEIVED



1634

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>126 E. MAIN ST.</u>		d. STREET ADDRESS <u>1 126 E. MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE LEE BEAVER</u>		4. DATE OF DEATH Month Day Year <u>FEB. 20 1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WESTMINSTER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW J. BEAVER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH MAGEE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>MRS. JOSEPHINE WEST, WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 6 mo.</u> <u>about 5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Clinically carcinoma of colon (no X-ray or P. 21 to verify)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 1<sup>st</sup></u> , 1956, to <u>Feb. 20</u> , 1957, that I last saw the deceased alive on <u>Feb. 19</u> , 1957, and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D. <u>Westminster, Md.</u>		DATE SIGNED <u>Feb. 21, 1957</u>	
PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB. 23, 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

**RECEIVED**  
FEB 25 1957  
BUREAU V. S.

CERTIFICATE OF DEATH

01651

Reg. Dist. No. 16

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hale Nursing Home</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Loretta</b> Last <b>Bishop</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>2</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1872</b>
9. AGE (In years last birthday) <b>72 1/2</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Glacken</b>		14. MOTHER'S MAIDEN NAME <b>Sarah wolf</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Jacob Bishop</b>		Address <b>Manchester, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocarditis Chronic Decompensating</b> 4477 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension</b> DUE TO (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-16-57</b> to <b>2-2-57</b> , that I last saw the deceased alive on <b>2-2-57</b> 19 <b>57</b> , and that death occurred at <b>6 A.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Raffell</b>		ADDRESS (Street, city or town, state) <b>Reisterstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James G. Raffell</b>		DATE SIGNED <b>Reisterstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 5, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.E. Myers Jr.</b>		ADDRESS <b>Westminster, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 2-4-57</b>		24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>	

EAU V. S.

-B 6 100

RECEIVED

1641

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

1 PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MARYLAND</u> b COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENEDUM ST</u>		d. STREET ADDRESS <u>BENEDUM ST.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>T. MAY BOND</u>		4. DATE OF DEATH Month Day Year <u>FEB. 16 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14 - 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOLTEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	9. AGE (In years last birthday) yrs. <u>77</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CORNELIUS BOND</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH ENGLAR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MRS. M. GRIMES, UNION BRIDGE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MD 6, 1956</u> , to <u>Feb 16, 1957</u> , that I last saw the deceased alive on <u>2/1/57</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Pegg</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Union Bridge MD</u>	
PHYSICIAN'S NAME (Type) <u>T. H. WEGG MD</u>		<u>Union Bridge MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB 19 - 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>JOHNSVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hatcher Sons, Union Bridge MD</u>		24a. REC'D BY REGISTRAR DATE <u>2/18/57</u>	24b. REGISTRAR'S SIGNATURE <u>James X. Pegg</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. B.

FEB 20 1957

RECEIVED

1645

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3 mos, 29 dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rocky Ridge</b>	
		d STREET ADDRESS <b>unk.</b>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>William</b> Last <b>BOONE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26th. 1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR: Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Boone</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Yingling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-14-6664</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>			
DUE TO (b) <b>Infected embolus</b>			
DUE TO (c) <b>Acute abscesses of prostate &amp; Parotid gland; organism not determined</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 27, 1957</b> to <b>February 26, 1957</b> , that I last saw the deceased alive on <b>February 26, 1957</b> , and that death occurred at <b>6:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		DATE SIGNED <b>2/27/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>3-1-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Naugh's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Ladiesburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Kruger</b>		ADDRESS <b>Thurmont, Maryland</b>	
DATE <b>2/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>Harry Kerp</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 1 1957

RECEIVED

1635

## CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	
c. LENGTH OF STAY IN 1b <b>78 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>70 LIBERTY ST.</b>		d. STREET ADDRESS <b>170 LIBERTY</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CASE</b> Last <b>CASE</b>		4. DATE DEATH Month <b>2</b> Day <b>1</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 6-1878</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR: Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY CASE</b>		14. MOTHER'S MAIDEN NAME <b>MARY BEAVER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-07-4419A</b>	
17. INFORMANT <b>Mrs. MARGARET E. CASE</b>		Address <b>70 LIBERTY ST. WESTMINSTER, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis (chr), Nephritis chr</b> <b>34.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic aortic</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1957</b> , to <b>2-1-57</b> , that I last saw the deceased alive on <b>1-31-57</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm C. Bennett</b>		ADDRESS (Street, city or town, state) <b>103 E. Main Westminster Md</b>	
DATE SIGNED <b>2-2-57</b>			
PHYSICIAN'S NAME (Type) <b>Wm C. Bennett MD Westminster Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-4-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>WESTMINSTER, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David G. Bankard Westminster Md.</b>		24a. REC'D BY REGISTRAR DATE <b>2-4-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director.

U. S. A.

FEB 6 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01655

CERTIFICATE OF DEATH

Reg. Dist. No.

1646

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Windsor</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Windsor</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMMA CORDELIA CLARY</b>		4. DATE OF DEATH Month Day Year <b>Feb 25 1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 14-1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Purdum</b>		14. MOTHER'S MAIDEN NAME <b>Martha Molesworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Oliver Magin</b> Address <b>New Windsor Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Stomach</b> <b>101X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1955</b> to <b>Feb 25, 1957</b> , that I last saw the deceased alive on <b>Feb 25, 1957</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James T. Marsh</b> M.D.		ADDRESS (Street, city or town, state) <b>Washington Md</b> DATE SIGNED <b>2-27-57</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Feb 28-1957</b>	<b>Prospect</b>	<b>Mt Airy Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>D D Hartzler &amp; Sons</b> ADDRESS <b>New Windsor Md</b>		24a. REC'D BY REGISTRAR <b>March 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Emmi S. Benschel</b>

FEDERAL BUREAU OF INVESTIGATION

MAR 5

FILED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1647

## CERTIFICATE OF DEATH

Reg. Dist. No.

01656  
(01656)  
74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>23yrlmo23days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>610 Gutman Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Bernard</b> Last <b>CLEARY</b>				4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1885</b>	
9. AGE (In years last birthday) <b>71 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James H. Cleary</b>				14. MOTHER'S MAIDEN NAME <b>Anna Measa</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Springfield State Hospital Records - Sykesville</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Annular Carcinoma of rectal-sigmoid junction.</b>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>Schizophrenia.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>September 11, 1933, to February 4, 1957</b> , that I last saw the deceased alive on <b>February 4, 1957</b> , and that death occurred at <b>7:00A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Martin Gross</b> M.D. <b>Springfield State Hospital</b> <b>2-4-57</b>							
NAME (Type) <b>Martin Gross, M. D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>							
22b. DATE THEREOF <b>2/7/57</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL CEM.</b>							
22d. LOCATION (City, town, or county) (State) <b>Balto., City</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>WIEDEFELD &amp; SON</b>							
ADDRESS <b>GREENMOUNT AVE &amp; BEND</b>							
24a. REC'D BY REGISTRAR <b>2-6-57</b>							
24b. REGISTRAR'S SIGNATURE <b>C. Harry Keene</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEAU V. S.

FEB 7 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01657

Reg. Dist. No. 76

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Carroll</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Carroll</span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">rural--Westminster</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">--</span>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Rural--Westminster</span>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Warfieldsburg</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">1 Nicodemus Rd.</span>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-around; font-size: 1.2em;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <span style="font-size: 1.5em;">ALLEN ROGER CLEGG</span>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-around; font-size: 1.2em;"> <span>Month</span> <span>Day</span> <span>Year</span> </div> <span style="font-size: 1.2em;">Feb. 12, 19 57</span>									
<b>5. SEX</b> <span style="font-size: 1.2em;">MALE</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">W</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <div style="display: flex; justify-content: space-around; font-size: 1.2em;"> <span>WIDOWED <input type="checkbox"/></span> <span>DIVORCED <input type="checkbox"/></span> <span>Nov. 11, 1935</span> </div>		<b>9. AGE</b> (in years last birthday) <span style="font-size: 1.2em;">21</span> yrs.		<b>IF UNDER 1 YEAR</b> Months      Days		<b>IF UNDER 24 HRS</b> Hours      Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">laborer</span>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">general</span>				<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Virginia</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">ROGER MILTON CLEGG</span>						<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Cecil Mauck</span>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">no</span>				<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">216-30-3474</span>				<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Roger M. Clegg, Westminster, Md.</span>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b>  <span style="font-size: 1.2em;">910.1</span> <span style="float: right;">DUE TO</span>                  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.             </div> <div style="width: 50%; border-left: 1px solid black; padding-left: 10px;"> <span style="font-size: 1.5em;">Fracture of Base of Skull</span>  <span style="float: right; font-size: 1.2em;">Interval between onset and death</span> </div> </div>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.2em;">True fall striking him on head.</span>									
<b>20c. TIME OF INJURY</b> Month, Day, Year <div style="display: flex; justify-content: space-between; font-size: 1.2em;"> <span>Hour</span> <span>a.m.</span> <span>p.m.</span> </div> <span style="font-size: 1.2em;">3 2-12-57</span>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">NEIGHBOR'S FARM</span>		<b>20f. (City or town)</b> <span style="font-size: 1.2em;">RTE 27 CARROLL</span>		<b>(County)</b> <span style="font-size: 1.2em;">MD</span>		<b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">M.C. Porter filed</span>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">Maurice C. Porterfield, M.D.</span>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <span style="font-size: 1.2em;">2-12-57</span>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">BURIAL</span>				<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">2-15-1957</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Mt. Zion</span>				<b>22d. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Carroll CO., Maryland</span>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">C. M. Waltz,</span>						<b>ADDRESS</b> <span style="font-size: 1.2em;">Winfield, Maryland</span>							
<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">DATE 2/15/57</span>						<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Harriet Miller</span>							

DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 4 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

1957

RECEIVED

1649

## CERTIFICATE OF DEATH

Reg. Dist. No.

50

1. PLACE OF DEATH <sup>a</sup> a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				e. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSE</u> <u>LEE</u> <u>CRAWMER</u>				4. DATE OF DEATH Month Day Year <u>FEB</u> <u>23</u> <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 7-1875</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEPUTY SHERIFF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COUNTY SHERIFF</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JESSE CRAWMER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE CRAWMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, no. or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>HELEN LITTLE NEW WINDSOR RURAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial (cl) Thrombosis (cl)</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 1950, to <u>Feb 23</u> , 1957, that I last saw the deceased alive on <u>Feb 23 - 1957</u> , and that death occurred at <u>7:20 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. E. Bennett</u>				DATE SIGNED <u>103 E Main Westminster MD 2-25-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Carl Jernette</u>				<u>Westminster, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 26-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler &amp; Sons New Windsor</u>				24a. REC'D BY REGISTRAR DATE <u>24/1957</u>		24b. REGISTRAR'S SIGNATURE <u>Ernie S. Burchett</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

U. S. DEPT. OF JUSTICE

1650

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Westminster</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Westminster</b>			
c. LENGTH OF STAY IN 1b <b>3 mo.</b>				d. STREET ADDRESS <b>Kate Wagner Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WALTER E. CROUSE</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-3-1874</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O.R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George E. Crouse</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Molesworth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-07-7269</b>		17. INFORMANT <b>Mrs. Edna E. Crouse,</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>fractured hip</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>14 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic C-V disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Tripped and fell</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>Feb 11 1957</b> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
				20f. (City or town) <b>Westminster</b>		20g. (County) <b>Carroll</b>	
				20h. (State) <b>MD</b>			
21. I certify that I attended the deceased from <b>Feb 11</b> , 19 <b>57</b> , to <b>Feb 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb 25</b> , 19 <b>57</b> , and that death occurred at <b>8:05 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James J. Marsh</b>				ADDRESS (Street, city or town, state) <b>Westminster Md</b>		DATE SIGNED <b>2-26-57</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-1-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Airy, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>				ADDRESS <b>Winfield, Maryland</b>		24. REC'D BY REGISTRAR <b>Feb 28 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carroll Miller</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

PLATE



01660

1651

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr, 8mos, 28dy</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>101 Virginia Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Ernest</b> Last <b>Dodson</b>			4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>19 57</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 9, 1868</b>	9. AGE (in years last birthday) <b>88</b>	IF UNDER 1 YEAR Months <b>88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hairdresser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beauty Shoppe</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Henry Ernest</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ward</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Springfield Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction</b>					INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield State Hospital</b>	
20f. (City or town) <b>Rockville, Md.</b>		20g. (County) <b>Montgomery</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>May 27, 1954</b> to <b>February 25, 1957</b> , that I last saw the deceased alive on <b>February 25, 1957</b> , and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>2/25/57</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial XXXX</b>		22b. DATE THEREOF <b>2/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Rockville, Md.</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>		ADDRESS <b>Laytonville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>2-28-57</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Z...</b>					

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1652

## CERTIFICATE OF DEATH

01661

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Finksburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg - Rural</b>	
c. LENGTH OF STAY IN <b>4 months</b>		d. STREET ADDRESS <b>Deer Park Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RT 1 Finksburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
II. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>Elizabeth</b> Middle <b>Edmonston</b> Last		4. DATE OF DEATH <b>Feb</b> Month <b>10</b> Day <b>1957</b> Year	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 17 - 1870</b> 9. AGE (In years, last birthday) <b>86</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Robert Francis Warner</b>		14. MOTHER'S MAIDEN NAME <b>Mellisa Jane Potter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Owen Edmonston</b> Address <b>Finksburg RT 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>4 years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/20</b> , 19 <b>56</b> to <b>2/10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2/9</b> , 19 <b>57</b> , and that death occurred at <b>11:40 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Allen Moulton</b>		ADDRESS (Street, city or town, state) <b>148 W Main St Westminster</b>	
PHYSICIAN'S NAME (Type) <b>G. ALLEN MOULTON, M.D.</b>		DATE SIGNED <b>2/11/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/12/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>
22d. LOCATION (City, town, or county) <b>Kent County</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Amracost</b>		24a. REC'D BY REGISTRAR <b>2/14/57</b>	24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>

W

BOURBAU V. B.

1957



1653

CERTIFICATE OF DEATH

01662

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pattapsco</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pattapsco</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>✓</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES - W - ELSEWOOD</u>				4. DATE OF DEATH <u>Feb 9 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3 - 1872</u>	9. AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeremiah Elsewood</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Abbott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs Herbert Allgier - Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C-V Disease</u> DUE TO (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> , to <u>Feb 9 1957</u> , that I last saw the deceased alive on <u>Feb 7 1957</u> , and that death occurred at <u>10:00 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. C. Porterfield</u>				ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>		DATE SIGNED <u>2-10-57</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>				Hampstead, Md. <u>2/10/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Tipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Henry H. H.</u>	
				DATE <u>2/11/57</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1636

CERTIFICATE OF DEATH

Reg. Dist. No.

01663

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>30 W. Green St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE KEY ESSICK</u>				4. DATE OF DEATH Month Day Year <u>Oct 7 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 29, 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Henry Miller</u>			
14. MOTHER'S MAIDEN NAME <u>Susan Elizabeth Whitmore</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Miss Anna R. Essick, Westminster</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>42011</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 1, 1950</u> to <u>Feb 7, 1957</u> , that I last saw the deceased alive on <u>Feb 7, 1957</u> , and that death occurred at <u>4:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius Chepko</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>85 W. Green Westminster Md 7/8/57</u>			
PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hampton Lutheran Cemetery Keyman, Carroll Co., Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Meyer, Jr., Westminster, Md.</u>				24a. REG'D BY REGISTRAR DATE <u>2-8-57</u>		24b. REGISTRAR'S SIGNATURE <u>Thomas J. Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1654

## CERTIFICATE OF DEATH

01664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 29 34. 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>436 Rosecroft Terrace</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary Katherine</b> Middle <b>Garland</b> Last <b>FOX</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1883</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident, right side</b> DUE TO <b>351X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>0012X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. disturbance, with cerebral arteriosclerosis, with psychotic reaction, plus pulmonary tuberculosis.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 12, 1954</b> , to <b>February 7, 1957</b> , that I last saw the deceased alive on <b>February 7, 1957</b> , and that death occurred at <b>12:Midn.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b> DATE SIGNED <b>2/8/57</b>			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.		PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wough Chapel Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Weber Jr</b>		24a. REC'D BY REGISTRAR <b>2/10/57</b>	
ADDRESS <b>705 S. Penn st</b>		24b. REGISTRAR'S SIGNATURE <b>Harry H. Hays</b>	

RECEIVED

EB 1057

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 211 2-25-57 ams

## CERTIFICATE OF DEATH

01665

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1yr, 6mo, 16dy</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mathilda Margaret FRANKENBERG</b>				4. DATE OF DEATH <b>February 5, 1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 10, 1864</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael M. Nachbar</b>				14. MOTHER'S MAIDEN NAME <b>Susan M. Tilghman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>904.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture of hip</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>  <b>14 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reaction</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>patient was the reportedly injured patient by another patient</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>1/22/57</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Sykesville</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I attended the deceased from <b>July 19, 1955</b> , to <b>February 5, 1957</b> , that I last saw the deceased alive on <b>February 5, 1957</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
ACTUAL PHYSICIAN <b>Walther H. Sonnenfeldt, M.D.</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/5/57</b>			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Bald Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b> ADDRESS <b>5305 Harford Rd</b>				24a. REC'D BY REGISTRAR <b>DATE 2-5-57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Henry Allen</b>	

BUREAU V. S.

FEB 7 1901

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1637

## CERTIFICATE OF DEATH

### 01666

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>				c. LENGTH OF STAY IN lb <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>169 E. Green St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Norman</b> Last <b>Fringer, Sr.</b>				4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 25, 1873</b>	9. AGE (In years last birthday) <b>83</b> yrs	IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.	IF UNDER 24 HRS. Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>rt Lynotype Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>George N. Fringer</b>			
14. MOTHER'S MAIDEN NAME <b>Catherine D. Hoff</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>213-01-9281</b>				17. INFORMANT <b>Guy N. Fringer, Jr. Westminster, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Renal Disease</b> DUE TO (b) <b>Arterio Sclerosis (Genl)</b> DUE TO (c) <b>5 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Westminster</b>				20g. (County) <b>Carroll</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Feb 12</b> , 19 <b>57</b> , to <b>Feb 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb 18</b> , 19 <b>57</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. G. Speicher, M.D.</b>				DATE SIGNED <b>2/19/57</b>			
PHYSICIAN'S NAME (Type) <b>W. G. Speicher, M.D.</b>				ADDRESS (Street, city or town, state) <b>135 E. Main St. Westminster, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Westminster</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers Westminster, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 2-20-57</b>		24b. REGISTRAR'S SIGNATURE <b>Harriet Muller</b>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1638

## CERTIFICATE OF DEATH

01667

Reg. Dist. No.

76

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CARROLL CO</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>20 YRS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>138 S. MAIN ST.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>138 S. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOHN BYRON GARTRELL</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>FEB. 26 1957</u> Month Day Year			
<b>5. SEX</b> <u>M.</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JULY 21 1883</u> 9. AGE (In years last birthday) <u>72 yrs.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>CARROLL CO.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>STEPHEN F. GARTRELL</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARTHA W. LEATHERWOOD</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>?</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>?</u>		<b>17. INFORMANT</b> <u>MRS. HOLLY F. GARTRELL WESTMINSTER, MD.</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>arterio-sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>Probably 2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
				<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I attended the deceased from</b> <u>8-1</u> <u>1956</u> , to <u>2-26</u> <u>1957</u> , that I last saw the deceased alive on <u>2-25</u> <u>1957</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>C. L. Billingslea</u> M.D. <u>Westminster, Md.</u> <b>PHYSICIAN'S NAME (Type)</b> <u>C. L. Billingslea</u>						<b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b> <u>2-27-57</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>MARCH 1, 1957</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>WESTMINSTER CEM.</u>		<b>22d. LOCATION</b> (City, town, or county) <b>(State)</b> <u>WESTMINSTER, MD.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. S. Myers, Jr.</u> <u>Westminster, Md.</u> ADDRESS				<b>24a. REC'D BY REGISTRAR</b> <u>Heinrich, J. J.</u> DATE <u>2-28-57</u>		<b>24b. REGISTRAR'S SIGNATURE</b>	

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1656

## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carrollton</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bethel Road</b>		d. STREET ADDRESS <b>Bethel Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Franklin</b> Last <b>Green</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1897</b>
9. AGE (In years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR: Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>David Franklin Green</b>		14. MOTHER'S MAIDEN NAME <b>Edith Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-01-4606</b>	
17. INFORMANT <b>Miss Stella Green</b>		Address <b>Finksburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>3221</b> (b) <b>arteriosclerosis</b> DUE TO <b>arteriosclerosis</b> (c) <b>arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic alcoholism</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 11</b> , 19 <b>57</b> , to <b>Feb 13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb. 12</b> , 19 <b>57</b> , and that death occurred at <b>6:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>15 Kemper Ave. Westminster, Md.</b> DATE SIGNED <b>2/14/57</b>			
ACTUAL SIGNATURE <b>E. Reese Wilkens</b> M.D.		PHYSICIAN'S NAME (Type) <b>E. Reese Wilkens, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-16-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Carrollton Church of God</b>		22d. LOCATION (City, town, or county) (State) <b>Carrollton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Md.</b>	
24a. REC'D BY REGISTRAR <b>2-16-57</b>		24b. REGISTRAR'S SIGNATURE <b>H. C. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

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JUL 10 1957

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1657 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

016698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Westminster</b>		c. LENGTH OF STAY IN lb <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Westminster</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D. #5</b>				d. STREET ADDRESS <b>R.F.D. #5</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>HAINES</b> Last <b>HAINES</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>1,</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. ? 1896</b>		9. AGE (In years last birthday) <b>60</b> yrs.	10. UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John L. Haines</b>				14. MOTHER'S MAIDEN NAME <b>Fannie B. Wagner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT Address <b>Mrs. Fannie B. Haines, Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> <b>9250</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>minute</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Top slipped off straw stool - hurled her</b>					
20c. TIME OF INJURY Month, Day, Year <b>4:30 p.m. 2-1-57</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home farm</b>		20f. (City or town) (County) (State) <b>Westminster Carroll Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James T. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-5-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sams Creek Brethren</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>				ADDRESS <b>Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 5 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>James T. Marsh</b>			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1658

## CERTIFICATE OF DEATH

Reg. Dist. No.

01670

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>2,649 days</b>		d. STREET ADDRESS <b>2930 Southland Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lela</b> Middle <b>Mae</b> Last <b>Hammond</b>		4. DATE OF DEATH Month <b>2-</b> Day <b>4-</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1926</b>
9. AGE (In years last birthday) <b>30</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hammond</b>		14. MOTHER'S MAIDEN NAME <b>Alice Keno</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>102-20-6632</b>	
17. INFORMANT <b>Mrs. Alice Hammond - Highpoint N.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Far advanced bilateral cavitory pulmonary TB</b> <b>202X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 4, 1949</b> , to <b>February 4, 1957</b> , that I last saw the deceased alive on <b>February 4, 1957</b> , and that death occurred at <b>12:30A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>7. F. Vestal</b> M.D.		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>2-4-57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Tom F. Vestal, Supt.</b>		<b>Henryton State Hospital, Henryton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2.7.57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Highpoint N.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Funeral Home</b>		24. REC'D BY REGISTRAR <b>2-4-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Albert R. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 5 1977

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01671

1659

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Sykesville, Maryland</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Walkersville (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>6-1-1-1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Henry Hape</b>			First Middle Last		4. DATE OF DEATH Month <b>2</b> Day <b>18</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1871</b>		9. AGE (In years last birthday) <b>85</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hape</b>				14. MOTHER'S MAIDEN NAME <b>Margret Keeney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic rheumatic heart disease</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>2 days</b>							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with senile brain disease, with psychosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>January 29, 1957</b> , to <b>February 18, 1957</b> , that I last saw the deceased alive on <b>February 18, 1957</b> , and that death occurred at <b>6:50 A.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gertrude M. Gross, M.D.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>2-18-57</b>		PHYSICIAN'S NAME (Type) <b>Sykesville, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Hope</b>		22d. LOCATION (City, town, or county) (State) <b>Woodsboro Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. G. Barton</b>		ADDRESS <b>Walkersville md</b>		24a. REC'D BY REGISTRAR <b>DATE 2-22-1957</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Keeney</b>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 25 1957  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01672

1660

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>3012 Loch Raven Blvd., Balto. 18</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Blain</b> Last <b>IRVIN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 24, 1890</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Irvin</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ann Harris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-6600</b>		17. INFORMANT Address <b>Springfield Hospital records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> Years (c) <b>Generalized arteriosclerosis</b> Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>December 20, 1956</b> , to <b>Feb. 25, 1957</b> , that I last saw the deceased alive on <b>Feb. 25, 1957</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b> DATE SIGNED <b>2/25/57</b> ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/28/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>U.S. NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.F. Hoffmann</b>				ADDRESS <b>3218 Hudson St.</b>		24a. REC'D BY REGISTRAR <b>Feb. 26, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Harg</b>							

REAR V 41

7 27 1957

RECEIVED

# CERTIFICATE OF DEATH

166!

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Claude Stewart Isaacs</u>		4. DATE OF DEATH Month <u>Febr.</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-21-1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>M. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Isaacs</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-07-3251</u>	
17. INFORMANT <u>MRS. E. H. IRELAND-12 HILLSIDE RD.</u>		Address <u>CATONSVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterioclerotic heart disease</u> (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis C.B.S. ass. with cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>1-31-1957</u> to <u>2-12-1957</u> that I last saw the deceased alive on <u>2-11-1957</u> , and that death occurred at <u>12:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.		DATE SIGNED <u>2/12/57</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SHACKS CORNER HAWARD C. M.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>		24a. REC'D BY REGISTRAR <u>  </u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>		DATE <u>3 18 1957</u>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

**FULL-TIME DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHNSON V. S.

1957

RECEIVED

1662

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TANEY TOWN</u>				c. LENGTH OF STAY IN 1b <u>12 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9 MILL ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PAYMOND GARMAN KEEFER</u>				4. DATE OF DEATH <u>FEB. 13 1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-1899</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER, WESTMINSTER MD.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>CALVIN KEEFER</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE OTTO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>N</u>				16. SOCIAL SECURITY NO. <u>213-05-1388</u>		17. INFORMANT <u>BEULAH KEEFER TANEY TOWN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis (color) Hypertension Ch</u> <u>434.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac asthma</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 1945</u> , to <u>Feb. 13 1957</u> , that I last saw the deceased alive on <u>2-12-1957</u> , and that death occurred at <u>1045 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.C. Tennette</u>				ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md.</u> DATE SIGNED <u>2-17-57</u>			
PHYSICIAN'S NAME (Type) <u>W.C. Tennette</u>				ADDRESS <u>103 E Main Westminster Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-16-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM. RD. 7 WESTMINSTER MD.</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C. Banhard Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 2-17-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 20 1957

RECEIVED

1663

## CERTIFICATE OF DEATH

Reg. Dist. No.

714

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Palto City</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1 mo. 2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Claude</u> Last <u>KOOKEN</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 30, 1911.</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Meat</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Claude Kookan</u>		14. MOTHER'S MAIDEN NAME <u>Effie Kookan Fazenbaker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>225-01-0153</u>	
17. INFORMANT <u>Springfield Hospital Records.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant growth in brain - determination of</u> DUE TO <u>type pending microscopic findings.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with alcoholism with secondary multiple vitamin deficiency and malnutrition.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>January 5, 1957</u> , to <u>February 7, 1957</u> , that I last saw the deceased alive on <u>February 6, 1957</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2/7/57</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Philes Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Western Port, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. ...</u>		ADDRESS <u>...</u>	24a. REC'D BY REGISTRAR DATE <u>2-8-57</u>
		24b. REGISTRAR'S SIGNATURE <u>C. Harry ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

FEB 11 1957

151-100-100



MEDICAL CERTIFICATION

BUREAU V. S.

FEB 1 1907

RECEIVED

1665

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1mo., 27 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>Humbert Apts.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>Ferguson</b> Last <b>LOGUE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1957</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 1, 1878</b>	
9 AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Andrew Jackson Logue</b>				14. MOTHER'S MAIDEN NAME <b>Mary Emry Ward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-20-8545</b>			
17. INFORMANT <b>Springfield Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> <b>441X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease; C.B.S. asso. with cerebral arterio-sclerosis with psychotic reaction.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 4, 1956</b> , to <b>February 1, 1957</b> , that I last saw the deceased alive on <b>February 1, 1957</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>2/1/57</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-4-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park</b>		22d. LOCATION (City, town, or county) (State) <b>Simmlerwood, Carroll, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Byer - Westminster, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 2-2-57</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. Perry</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 4 1957

RECEIVED

## \* 1666 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN IB <u>5 mos. 22 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. STREET ADDRESS <u>7104 Exeter Rd., Bethesda</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Trenholm</u> Last <u>LYMAN</u>		4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Trenholm</u>		14. MOTHER'S MAIDEN NAME <u>Mary Burroughs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>744</u>	
17. INFORMANT <u>Springfield Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9047</u> (b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>C.P.S. asso. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction. Fracture of pubic bone.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Patient found lying on floor.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12/26/ 1956</u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>
20f. (City or town) <u>Sykesville</u>		(County) <u>Carroll</u>	(State) <u>Md.</u>
21. I certify that I attended the deceased from <u>August 16, 1956</u> , to <u>February 8, 1957</u> , that I last saw the deceased alive on <u>February 7, 1957</u> , and that death occurred at <u>12:25 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		ADDRESS (Street, city or town, state) <u>Springfield Hospital,</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>		DATE SIGNED <u>2/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>
22d. LOCATION (City, town, or county) <u>Washington D.C.</u>		(State) <u>D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>2-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01679

1667

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES WILLIAM MACKLEY</u>				4. DATE OF DEATH Month Day Year <u>FEB. 13 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 21-1877</u>		9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>MILTON A MACKLEY</u>			
14. MOTHER'S MAIDEN NAME <u>MARY LITTLE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>214-14-7601</u>				17. INFORMANT Address <u>Mrs Fred Eyles, Union Bridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular disease.</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/21</u> , 19 <u>56</u> to <u>2/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/13</u> , 19 <u>57</u> , and that death occurred at <u>P.A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u>				M.D. <u>New Windsor, Md</u>		DATE SIGNED <u>2/13/57</u>	
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>				ADDRESS (Street, city or town, state) <u>NEW WINDSOR, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 16-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartley &amp; Sons</u>				ADDRESS <u>Union Bridge</u>		24a. REC'D BY REGISTRAR DATE <u>2/14/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

U. S. AIR FORCE

FEB 1955

RECEIVED



1668

## CERTIFICATE OF DEATH

01680

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>5yr, 5mo, 1dy</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Margaret</b> Last <b>MAJCHRAK</b>				4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1899</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland-</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph Cork</b>				14. MOTHER'S MAIDEN NAME <b>Rose Zaporowska</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant melanoma or thigh, Grade 4</b> <b>190X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, paranoid type, plus arrested pulmonary tuberculosis.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>p. m.</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>October 20, 1954</b> , to <b>February 8, 1957</b> , that I last saw the deceased alive on <b>February 8, 1957</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>		DATE SIGNED <b>2/8/57</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		22d. LOCATION (City, town, or county) (State) <b>Dundalk Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Linka</b>				ADDRESS <b>2829 Hudson St.</b>		24a. REC'D BY REGISTRAR <b>C. Harry Wees</b>	
				<b>Baltimore 24 Md.</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Wees</b>	

U.S.

DECEMBER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01681

1669

## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>				c. LENGTH OF STAY IN 1b <b>70 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>417 E. Main St.</b>				d. STREET ADDRESS <b>417 E. Main St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Martin</b> Last <b>Mancha</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 1, 1875</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Builder</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Lewis Mancha</b>				14. MOTHER'S MAIDEN NAME <b>Louisa Riffle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Edward M. Mancha</b> Address <b>Westminster, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of intestine.</b> <b>5.3 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metast. in liver &amp; lung (R)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1956</b> to <b>Feb 11, 1957</b> , that I last saw the deceased alive on <b>2-10-1957</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>103 E. Main Westminster Md</b> DATE SIGNED <b>2-12-57</b>							
ACTUAL SIGNATURE <b>W. C. Jennette</b> M.D.				PHYSICIAN'S NAME (Type) <b>W. C. Jennette, M.D.</b> <b>103 E. Main St. Westminster, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-14-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Westminster</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b> ADDRESS <b>Westminster, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 2-14-57</b>		24b. REGISTRAR'S SIGNATURE <b>H. Ernst</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 2 1907

RECEIVED

1670

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>74 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>68 1/2 MADISON ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>A.</u> Last <u>MANCHA</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 13, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER RET. LUMBER YARD</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS MANCHA</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE RIFFLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-01-1704</u>		17. INFORMANT <u>Bessie H Mancha</u> Address <u>68 1/2 Madison Westminister Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Prostate</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1956</u> , to <u>Feb 20, 1957</u> , that I last saw the deceased alive on <u>Feb 20, 1957</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius Chepko</u> M.D.				ADDRESS (Street, city or town, state) <u>85 1/2 W Green Westminister Md</u>		DATE SIGNED <u>2/20/57</u>	
PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-22-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward R. Bankard</u> ADDRESS <u>Westminister Md.</u>				24a. REC'D BY REGISTRAR <u>Harold Miller</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 25 1957

BUREAU V. S.

1671

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Day P.O.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Charissa</u> Middle <u>Marshall</u> Last		4. DATE OF DEATH <u>Feb</u> Month <u>11</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1865</u>
9. AGE (In years last birthday) <u>91</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marion M. Mills</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Gosnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Alma Harvey - Woodbine, md.</u>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)}		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardio-vascular disease</u> <u>440*</u> DUE TO		20 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>general arteriosclerosis</u> DUE TO	
(c) <u>senile changes</u>		30 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1935</u> , 19____, to <u>11 February 1957</u> , that I last saw the deceased alive on <u>11 February</u> , 19 <u>57</u> , and that death occurred at <u>11:05 A.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Lawson, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>2-12-57</u>	
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr.</u> M.D.		<u>Sykesville P.O., Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elk Springs</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haiglet - Sykesville, md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-12-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Robert L. Smith</u>			

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S. A. COTTON

RECEIVED



74

**MEDICAL CERTIFICATION**

VS A15 (4)  
15M 9/55

BUREAU V. F.

EB 20 1957

RECEIVED

1673

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. LENGTH OF STAY IN 1b <u>4 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 7</u>				d. STREET ADDRESS <u>R7</u>			
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>ARTHUR</u> Last <u>MIELKE</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 23, 1882</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Mielke</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Schaulk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Evelyn Gunther Westminster Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO (b) <u>A.S.C.D. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1952</u> to <u>Feb 17</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. Morrah</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>				DATE SIGNED <u>2/17/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 20 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wards Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Holbrook, Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellis Amoran</u>				ADDRESS <u>4310 Liberty Heights Avenue</u>		24a. REC'D BY REGISTRAR <u>Harriet Miller</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

FEB

RECEIVED

1675

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Md.</u>			
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>				d. STREET ADDRESS <u>128 W main st.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Cora</u> First Middle Last <u>B. Morgan</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1957</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 30, 1892</u>				
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Robert Boyce</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Bonnet</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>W. Boyce Morgan, 6919 Selkirk Dr. Bethesda Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Coarctation</u> DUE TO <u>Arterio-sclerotic Cerebrovascular disease?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>—</u> (c) <u>—</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A JUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Sept 25</u> , 1954, to <u>February 18</u> , 1957, that I last saw the deceased alive on <u>Feb 18</u> , 1957, and that death occurred at <u>9:30 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Hampstead Md</u> <u>2-18-57</u>					
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>Hampstead Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-1957</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Sharon Pa</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Clifton</u>		ADDRESS <u>Hampstead Md</u>					
24a. REC'D BY REGISTRAR <u>Feb 20/57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. S. Denner</u>					

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 25 1957

RECEIVED

## 167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7, Film 6-223, 11-27-57, 27

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN lb <u>20 years</u>		d. STREET ADDRESS <u>5205 Windsor Mill Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Irene Agnes Miller</u>		4. DATE OF DEATH Month Day Year <u>Febr. 21 1957</u>	
5-SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>Married</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/28/1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Carroll</u>	
14. MOTHER'S MAIDEN NAME <u>Sally Thomas</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, list war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>HOSPITAL RECORDS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c) <u>260x</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Debilis nullus - Psychoneurosis - Reactive depression</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-26-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Schwalb</u>		24a. REC'D BY REGISTRAR <u>DATE 26 1957</u>	
ADDRESS <u>2101 Endicott Ave</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Keers</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
FEB 25 1957  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01688

Reg. Dist. No.

<b>1676</b>				<b>1676</b>			
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Carroll</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keysville</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D. Keymar</b>				d. STREET ADDRESS <b>R.D. Keymar</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>JOSEPH E. MULLER</b>				<b>4. DATE OF DEATH</b> Month <b>FEB.</b> Day <b>7,</b> Year <b>19 57</b>			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>6-10-1956</b>	
<b>9. AGE</b> (In years last birthday) yrs. <b>27</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>none</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>----</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>		<b>13. FATHER'S NAME</b> <b>Charles Muller Jr.</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Hannah J. Ecker</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>----</b>		<b>17. INFORMANT</b> <b>Charles Muller Jr., R.D. Keymar, Md.</b>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Acute Respiratory Infection</u> <b>475X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <b>19</b> <span style="float: right;">Month, Day, Year</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>(inspection)</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>James J. Marsh</u> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>JAMES T. MARSH</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>2-9-1957</b>		<b>22c. NAME OF CEMETERY</b> <b>Salem</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Carroll Co., Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C. M. Waltz,</b>				<b>24a. REC'D BY REGISTRAR</b> <b>Feb 11 1957</b>			
<b>ADDRESS</b> <b>Winfield, Maryland</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Eric Benedict</u>			

1000 224XY4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

3 11 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY in lb <b>2mos. 9days.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3034 Abell Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Baltimore, Maryland.</b>			
3. NAME OF DECEASED (Type or print) First <b>Rita Louise Hild</b> Middle <b>NIELSEN</b> Last				4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1914</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Thresh</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Hild</b>				14. MOTHER'S MAIDEN NAME <b>Anna McMann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Thresh</b>		17. INFORMANT Address <b>Springfield Hospital records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Interstitial and suppurative bronchopneumonia</b> (c) <b>Interstitia</b> DUE TO (a) stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>  <b>Days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <b>19</b> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James T. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook</b>				24a. REC'D BY REGISTRAR <b>2-20-57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Henry</b>	

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB 21 1967

BUREAU V. 1

## CERTIFICATE OF DEATH

1678

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <b>Rural - Sykesville</b>		since <b>11/11/49</b>		TOWN <b>Baltimore City</b>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Springfield State Hospital</b>				1019 S. Bouldin St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Patrick</b> (Middle) <b>-</b> (Last) <b>OATES</b>				February 20 19 57			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	married	November 12, 1871	85 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Gardener			Gardening		Ireland		unknown ✓
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<del>John Oates</del> <b>BARTHOLOMEW OATES.</b>				unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
no			unknown		Records of Springfield State Hospital		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A) <b>Coronary Occlusion</b>						1 day	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO						6 months	
(B) <b>Cerebral Vascular Accident</b>						more than	
(C) <b>Generalized Arteriosclerosis</b>						10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH						10 yrs. +	
<b>Senile Psychosis, simple deterioration.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec. 26, 1949</b> , to <b>2-20, 1957</b> , that I last saw the deceased alive on <b>2-20, 1957</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>Gertrude M. Gross, M.D.</i>				Sykesville, Maryland		2-20-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>2-20-57</b>		<b>HOLY REDEEMER CEM.</b>		<b>4430 BELAIR RD. BALTO, MD.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>2-21-57</b>		<i>C. Harry Hays</i>		<i>Charles L. Gile</i>		<b>901 S. CONKLING ST. BALTO, MD.</b>	

**INSTRUCTIONS**

**1** TO A PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO A FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

FEB 25 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03518

CERTIFICATE OF DEATH

01691

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN lb <b>since 9-8-56</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>9 Whitefield Rd</b>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Dawson</b> Last <b>Owens</b>				4. DATE OF DEATH Month <b>2</b> Day <b>1</b> Year <b>19 57</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-76</b>		9. AGE (In years last birthday) yrs <b>80</b>	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Comptroller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry F. Owens</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Weems</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unkn</b>		16. SOCIAL SECURITY NO <b>705-1261542</b>		17. INFORMANT <b>Mrs. Mildred P. Owens-9 Whitfield Rd. #10</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrovascular accident</b> (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 months plus years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psych. reactions</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 8, 1957</b> , to <b>Febr. 1, 1957</b> , that I lost sow the deceased alive on <b>Febr. 1, 1957</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>2-2-57</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>				Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tuckman</b>				ADDRESS <b>1344 E. Pa. Ave.</b>		24. REC'D BY REGISTRAR <b>Feb 4 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Kern</b>			

JOHN A. OWEN

1917

1917



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01692

1679

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Hampstead - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>-</u>			
3. NAME OF DECEASED (Type or print) <u>LOUIS-A-PARSONS</u>				4. DATE OF DEATH <u>Feb 10 - 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9 - 1872</u>	9. AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Burlington, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Albion Parsons</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Hillary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>920</u>			
17. INFORMANT <u>Mrs Pauline Parsons - Hampstead Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Oedema</u> <u>422.1</u> DUE TO (b) <u>Arterio-sclerotic C-V Diseases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3-4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1953</u> to <u>Feb 10 1957</u> that I last saw the deceased alive on <u>Feb 9 1957</u> and that death occurred of <u>USA</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>2-11-57</u>			
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>				Hampstead, Md. <u>2/11/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. Crpton, Hampstead Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>2/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>Henry Lewis</u>	

RECEIVED

FEB 7 1907

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01693

1680

## CERTIFICATE OF DEATH

Reg. Dist. No. 32-85

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>			c. LENGTH OF STAY IN 1b <u>17 yrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>East Church Street</u>				d. STREET ADDRESS <u>same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Poole</u>				4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Charles E. Phebus</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Crummitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Laura Chaney Mt. Airy</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>							<u>immediate</u>
260X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <u>Arteriosclerotic Heart Disease</u>							<u>4 years</u>
DUE TO							
(c) <u>Diabetes mellitus</u>							<u>more than 6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Feb. 9, 1957</u> to <u>February, 1957</u> , that I last saw the deceased alive on <u>Feb. 9, 1957</u> , and that death occurred at <u>12:30 p.m.</u> , from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <u>Mount Airy</u> DATE SIGNED <u>2/10/57</u>							
ACTUAL SIGNATURE <u>W.B. Culwell</u>				M.D. <u>Mount Airy</u>			
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>				<u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 12, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Moleworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-12-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert G. Hewitt</u>			

STANLEY A. B.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01694

1681

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Place deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN IB <b>2yrs. 4mos. 22days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>5 N. Exeter St.</b>	
3. NAME OF DECEASED (Type or print) <b>John Martin ROBERTS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christopher Columbus Roberts</b>		14. MOTHER'S MAIDEN NAME <b>-</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address <b>-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage</b> <b>540.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Peptic ulcer</b> DUE TO (c) <b>-</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with dist. of metabolism, with senile brain disease, with psychotic reaction.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 28, 1954</b> , to <b>Feb. 20, 1957</b> , that I last saw the deceased alive on <b>February 20, 1957</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		DATE SIGNED <b>2/21/57</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset</b>		22d. LOCATION (City, town, or county) (State) <b>Shelby N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Palmer - M. Paul - Shelby, N.C.</b>		24a. REC'D BY REGISTRAR <b>Feb 21/57</b>	
ADDRESS <b>Shelby, N.C.</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Wood</b>	

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FEB 25 1957  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

# 1682

## CERTIFICATE OF DEATH

01695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> City <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN IB <b>5yrs. 2mos. 25days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>4700 Harford Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henrietta</b> Middle <b>M.</b> Last <b>SCHOTT</b>				4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 26, 1873</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>factory Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>				12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>44000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Senile psychosis, simple deterioration, arteriosclerotic convulsions</b>							INTERVAL BETWEEN ONSET AND DEATH Days <b>1</b> Years <b>1</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis, simple deterioration, arteriosclerotic convulsions</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 6, 1951</b> , to <b>February 1, 1957</b> , that I last saw the deceased alive on <b>February 1, 1957</b> , and that death occurred at <b>11:30PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>2/2/57</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Buried</b>		<b>2-5-57</b>		<b>Baltimore, Md.</b>		<b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Baltimore</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>2-7-57</b>	
						24b. REGISTRAR'S SIGNATURE <b>C. Henry Jones</b>	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01696

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Black Rock Road</u>		d. STREET ADDRESS <u>Black Rock Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Ann</u> Last <u>Schultz</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert E. Mumpman</u>	
14. MOTHER'S MAIDEN NAME <u>Rosella K. Amacost</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>121-10 9890</u>		17. INFORMANT <u>Mrs Mary Cole</u> Address <u>Hampstead, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion Aorta</u> DUE TO (b) <u>Hypertensive Cardiac Vascular Disease</u> DUE TO (c) <u>12 hours</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Feb 14 1956</u> to <u>February 3 1957</u> , that I last saw the deceased alive on <u>February 2 1957</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		DATE SIGNED <u>2/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Henry Jones</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>2/4/57</u>	

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1681  
CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Finksburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Rural--Finksburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gamber</b>		d. STREET ADDRESS <b>Gamber</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>S.</b> Last <b>SHIPLEY</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>19,</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-8-1881</b>
9. AGE (In years last birthday) <b>76</b> yn		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John R. Paynter</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Grove M. Shipley, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of liver</b> DUE TO <b>metastases to lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cachexia</b> (c) <b>Cachexia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>✓</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-1-56</b> to <b>2-19-57</b> 19____, that I last saw the deceased alive on <b>2-17-57</b> 19____, and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Saffell</b>		DATE SIGNED <b>2-19-57</b>	
PHYSICIAN'S NAME (Type) <b>James G. Saffell</b>		ADDRESS (Street, city or town, state) <b>Reisterstown Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-22-1957</b>	22c. NAME OF CEMETERY <b>Providence</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Maryland</b>	
24a. RECEIVED BY REGISTRAR <b>FEB 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Harriet Mullen</b>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 21 1957  
BUREAU V. S.

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>573 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. STREET ADDRESS <b>2141 W. North Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Millie</b> Middle <b>Snowden</b> Last		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-11-1877</b>
9. AGE (In years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Kate Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Millie Snowden - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Far adv. bilateral pulm. TB with cavitation</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 27, 19 55</b> , to <b>Feb. 19, 19 57</b> , that I last saw the deceased alive on <b>Feb. 19, 19 57</b> , and that death occurred at <b>12:35A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>2-20-57</b>			
ACTUAL SIGNATURE <b>T. F. Vestal</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Tom F. Vestal, Supt.</b> <b>Henryton State Hospital, Henryton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. Jackson Funeral Home Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>2-20-57</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Albert R. ...</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page [redacted] may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Page [redacted] and 2 should be filled with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

BUREAU W. E.

1957

RECEIVED

1686

## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Westminster, Md. R. D. 1</b>				d. STREET ADDRESS <b>Westminster, Md. R. D. 1</b>			
3. NAME OF DECEASED (Type or print) <b>Maggie J. Sterner</b>				4. DATE OF DEATH Month <b>2/8/57</b> Day Year <b>19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/24/1879</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework, Housewife, Retired, Own home.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Carroll Co., Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Leese</b>				14. MOTHER'S MAIDEN NAME <b>Leah Brillhart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Chester Petry</b> Address <b>Mrs. Chester Petry Westminster, Md. R.D.1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Common infection, Myocardial infarction</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1950</b> to <b>2-8-57</b> , 19____, that I last saw the deceased alive on <b>2-7-57</b> , 19____, and that death occurred at <b>10:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. C. [Signature]</b> M.D.				ADDRESS (Street, city or town, state) <b>Westminster, Md.</b> DATE SIGNED <b>2-8-57</b>			
PHYSICIAN'S NAME (Type) <b>Wm. Carl Sennette M.D. Westminster Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b> ADDRESS <b>Littlestown, Pa.</b>				24a. REC'D BY REGISTRAR DATE <b>2-8-57</b>		24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 13 1957

WILLIAM V. S.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01700

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

Form 14, 9-27-G 210 2-7-57L

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>since 8-1-56</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>6202 Elliott Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Estella</b> Last <b>Waters</b>				4. DATE OF DEATH Month <b>2</b> (second) Day <b>19</b> Year <b>57</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-19 80</b>	9. AGE (In years last birthday) <b>76</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA (naturalized)</b>
13. FATHER'S NAME <b>John Bilek</b>				14. MOTHER'S MAIDEN NAME <b>Anna Karas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unkn</b>		16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>4 + 1</b> INDEX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebrovascular accident</b> DUE TO (c) <b>6 months</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chron. brain syndr. assoc. with cerebral arterioscler. with psych. react.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 1, 1956</b> to <b>Febr. 1, 1957</b> , that I last saw the deceased alive on <b>2-1-1957</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2-2-57</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				M.D. <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>				<b>Sykesville, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-5-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street.</b>				24a. REC'D BY REGISTRAR DATE <b>2-2-57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Edger</b>	

BUREAU V. S.

FEB 4 1937

RECEIVED

1688  
CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
c. LENGTH OF STAY IN 1b <u>30 yrs</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DENTON - J - WERTZ</u>		4. DATE OF DEATH <u>Feb 8 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 17-1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer</u>	
11. BIRTHPLACE (State or foreign country) <u>Wid</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter A Wertz</u>		14. MOTHER'S MAIDEN NAME <u>Julia Koler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-7483A</u>	
17. INFORMANT <u>Harvey Wertz - Manchester Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 1947</u> , to <u>Feb 8 1957</u> , that I last saw the deceased alive on <u>Feb 8 1957</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Foard</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md.</u>	
NAME (Type) <u>W. H. Foard M.D.</u>		DATE SIGNED <u>2/9/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 11-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Burial Co. E. W. B.</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. C. Tipton</u>		24a. REC'D BY REGISTRAR <u>Feb 9-57</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs W. P. Denner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 12 1907

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>X X X X</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville #2</b>		c. LENGTH OF STAY IN 1b <b>2½ Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Grand View Mansion, Sykesville #2, Md.</b>		d. STREET ADDRESS <b>4431 Alan Drive</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Wienert</b>		4. DATE OF DEATH Month Day Year <b>February 27 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1874</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>27 1957</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>X X X X</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Peter Goerke</b>		14. MOTHER'S MAIDEN NAME <b>Anna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>X X X X</b>	
17. INFORMANT Address <b>Gertrude Hinrichs 4431 Alan Drive, Baltimore</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease with</b> <b>arteriosclerosis and chronic myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>advanced senile changes</b> DUE TO (c) <b>20 yrs(?)</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>30 August</b> , 19 <b>54</b> , to <b>27 February</b> 19 <b>57</b> , that I last saw the deceased alive on <b>27 February</b> 19 <b>57</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. H. Lawson, Jr., M.D.</b>		ADDRESS (Street, city or town, state) <b>Liberty Road at Eldersburg</b> DATE SIGNED <b>2.27.57</b>	
PHYSICIAN'S NAME (Type) <b>Wm. H. Lawson, Jr., M.D.</b>		Sykesville P.O., Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/1/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>	22d. LOCATION (City, town, or county) (State) <b>Baeto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke</b> ADDRESS <b>4101 Edmond</b>		24a. REC'D BY REGISTRAR <b>C. Harry Keen</b> 24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

MAR 1 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>7mo. 15days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRINGFIELD STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>1400 W. Lexington St.</u>							
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Arthur</u> Last <u>YOUSE</u>				4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-79</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Christian Jacob Youse</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Ebert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-7642</u>		17. INFORMANT <u>Springfield State Hosp. records - Sykesville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-13</u> , 19 <u>56</u> , to <u>2-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-28</u> , 19 <u>57</u> , and that death occurred at <u>12:45PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>2-28-57</u>							
ACTUAL SIGNATURE <u>Martin Gross</u> M.D. <u>Springfield State Hospital</u>				DATE SIGNED <u>2-28-57</u>			
PHYSICIAN'S NAME (Type) <u>Martin Gross, M. D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Random Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Park, Jr 1517 St Paul St. Balt.</u>				24a. REC'D BY REGISTRAR DATE <u>2/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>E. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

# CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>			
c. LENGTH OF STAY IN 1b <u>2 YRS.</u>				d. STREET ADDRESS <u>R.D. 4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. 4</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PIERCE</u> First <u>H.</u> Middle <u>ZILE</u> Last				4. DATE OF DEATH <u>FEB.</u> Month <u>16</u> Day <u>1957</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 10-1888</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES ZILE</u>				14. MOTHER'S MAIDEN NAME <u>MARY HAHN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MARY G. ZILE WESTMINSTER, MD</u> Address <u>R.D. 4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial degeneration</u> DUE TO <u>cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>renal disease</u> DUE TO (c) <u>2 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>emphysema</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 15, 1956</u> to <u>Feb. 16, 1957</u> that I last saw the deceased alive on <u>Feb. 9, 1957</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE <u>E. Reese Wilkens, M.D.</u>				ADDRESS (Street, city or town, state) <u>15 Kemper Rd, Westminster, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. Reese Wilkens, Westminster</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-19-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 2-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

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